STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155789	A. BUILDING 00 B. WING	09/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIDGEWOOD HEALTH CAMPUS	181 CAMPUS DR LAWRENCEBURG, IN 47025

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F0000	This visit was for the Investigation of Complaint IN00115487. Complaint IN00115487 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F441 and F514. Survey dates: September 17 and 18, 2012 Facility number: 012523 Provider number: 155789 AIM number: 201027870 Survey team: Penny Marlatt, RN Census bed type: SNF: 37 SNF/NF: 19 Residential: 39 Total: 95 Census payor type: Medicare: 30 Medicaid: 16 Other: 49 Total: 95 Sample: 4 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.	F0000	The submission of this Plan of Correction does not indicate an admission by RidgeWood Health Campus that the findings and allegations contained herein are accurate and true representations of the quality of care and services provided to the residents of RidgeWood Health Campus. This facility recognized it's obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (for Title 18/19 programs). To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed 9/24/12 Cathy Emswiller RN			

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F0441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on interview, observation and record review, the facility failed to ensure	F0441	1. RN#1 and LPN#1 were reeducated by the DHS/designee	10/15/2012

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	appropriate hand hygiene was utilized: A. in 2 of 2 dressing change observations with 2 facility staff in 1 of 3 residents reviewed for dressing changes in a sample of 4. (Resident #C, RN #1, LPN #1) B. in 2 of 2 observations of blood glucose and/or insulin administration in 2 of 3 residents reviewed for blood glucose and insulin administration in a sample of 4. (Resident #C, Resident #D, RN #1) Findings include: A. Resident #C's clinical record was reviewed on 9-18-12 at 9:31 a.m. Her diagnoses included, but were not limited to diabetes and chronic leg wounds. Physician orders on 8-30-12 indicated to discontinue the previous treatment to the left shin and to begin daily dressings changes of cleansing the left shin wounds with normal saline, apply Santyl and cover with a dry dressing. In observation of the dressing change on 9-17-12 at 5:58 p.m. with RN #1, after the nurse was observed to remove the dressing and to discard the items in a bag with her gloved hands. She then removed her gloves and discarded them into the bag. She then donned a new set of gloves without hand hygiene being performed. She then continued with the dressing change by cleansing the left shin wounds		on proper hand washing technique with an emphasis on dressing changes and medication adminstration before 10/15/12. 2. All licensed staff were re-educated on proper hand washing technique with an emphasis on dressing changes and medication adminstration by DHS/designee before 10/15/12. 3. The DHS/designee will complete hand washing audits of licensed staff during dressing changes and medication administration to assure compliance. 4. These Audits will be conducted on 10% of licensed staff weekly x 3months, once 100% compliance is obtained audits will decrease to quarterly. Licensed staff will be reeducated and counseled as required. All audits will be reviewed during our daily CCM meeting, and montly during quality assurance meeting.	

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	with normal saline and dried the areas with gauze. She then discarded the items in a bag with her gloved hands and removed her gloves prior to performing hand hygiene. In a second observation of Resident #C's dressing change on 9-18-12 at 3:15 p.m. with LPN #1, the nurse was observed to remove the dressing and then to discard the items into a bag. Without changing gloves, she was observed to open the dressing supplies and to cleanse the left shin wounds with normal saline and to dry the area with gauze. She then removed the gloves and performed hand hygiene. B.1. During an observation with RN #1 on 9-17-12 at 4:22 p.m. with Resident #C, the nurse was observed to disinfect the glucometer after obtaining the resident's blood glucose. Hand hygiene was not observed to be performed after disinfecting the glucometer, nor prior to donning gloves. After donning the gloves, RN #1 then drew up Resident #C's insulin dosage. B.2. During an observation with RN #1 on 9-17-12 at 4:44 p.m. with Resident #D, the nurse was observed to administer 2 units of insulin to the resident at 4:49 p.m., followed by performance of hand			

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	hygiene. The nurse was then called to answer the telephone at the nurse's station prior to returning to the medication cart. She was not observed to perform hand hygiene after answering the telephone and prior to preparing medication for the next resident. In interview with RN #1 on 9-17-12 at 4:36 p.m., prior to providing care to Resident #D, she indicated, "We normally have hand sanitizer on the [medication] cart and I would normally wash my hands between residents. I guess I just forgot." In interview with RN #1 on 9-17-12 at 5:00 p.m., she indicated, "I should have redone the hand hygiene after I got off the phone." A policy entitled, "General Guidelines for Dressing Changes," with a effective date of December 2009 was provided by the Administrator on 9-18-12 at 3:37 p.m. This policy indicated, "...Wash hands with soap and water. Put on first pair of disposable gloves. Remove soiled dressing and discard in plastic bag. Dispose of gloves in plastic bag. Wash hands with soap and water. Put on second pair of disposable gloves. Follow doctor's recommendations for treatment. Apply dressing and secure with tape when done with treatment...Remove gloves and discard with all unused supplies in plastic			

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	bag. Wash hands with soap and water..." A policy entitled, "Specific Medication Administration Procedures," with an effective date of 2-1-2010 was provided by the Director of Nursing on 9-18-12 at 12:57 p.m. This policy indicated, "...Cleanse hands using antimicrobial soap and water or facility-approved hand sanitizer before beginning med pass, before handling medication, and before contact with the resident...When finished with each resident, wash hands with antimicrobial soap and water or use facility-approved hand sanitizer." A policy entitled, "Guidelines for Handwashing," with an effective date of October 2004, was provided by the Director of Nursing on 9-18-12 at 9:07 a.m. This policy indicated, "Handwashing is the single most important factor in preventing transmission of infections...Health Care Workers shall wash hands at times such as:...Before/after having direct physical contact with residents. After removing gloves, worn per Standard Precautions for direct care with excretions or secretions...resident equipment...Waterless hand cleaning products such as alcohol based gels, foams, rinses provide an acceptable alternative to handwashing in certain			

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	circumstances..." This federal tag relates to complaint IN00115487. 3.1-18(l)			

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F0514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure accurate documentation of care and services provided for 3 of 3 residents reviewed for diabetic care in a sample of 4 was provided. (Residents #A, #C and #D) Findings include: 1. Resident #A's clinical record was reviewed on 9-17-12 at 2:35 p.m. His diagnoses included, but were not limited to diabetes, neuropathy, osteomylitis (bone infection) and cellulitis (skin infection.) Physician orders indicated he was to have blood glucose or blood sugar (BG) testing performed before each meal and at bedtime, with a sliding scale dose of	F0514	1. DHS/designee notified residents #A, #C, and #D physcian to assure accuracy of insulin orders on 9-18-12. 2. All other residents with insulin orders were reviewed by the DHS/designee to assure no other residents were effected. Any deficient practice was corrected. 3. Licensed Staff have been in-serviced by DHS/designee related to ensuring that Insulin Orders are accurately documented. 4. DHS/ designee will review new Insulin orders and mars daily for one month, and then weekly for one month or until substantial compliance is achieved. Nurses will be educated and counseled as necessary for noncompliance. Ongoing monitoring will take place as part of daily CCM meetings and monthly QA.	10/15/2012

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	insulin to be given before each meal and at bedtime, based on the BG results. The sliding scale insulin orders indicated to give no insulin if the BG was under 141. From 141 to 200, to administer 4 units of insulin; from 201 to 250, administer 8 units of insulin; from 251 to 300, administer 12 units of insulin; from 301 to 350, administer 16 units of insulin; from 351 to 400, administer 20 units of insulin; for over 400, the facility was to contact the physician for instructions for care. Review of the Medication Administration Record (MAR) indicated on 8-18-12 at bedtime, the BG was 168; it indicated no insulin was administered. On 8-19-12 at breakfast, the BG was 387 and indicated 16 units of insulin were administered; at dinner time, the BG was 147 and indicated no insulin was administered; at bedtime, the BG was 305 and 4 units of insulin were administered. On 8-26-12, at breakfast, the BG was 438 and indicated no insulin was administered; at bedtime the BG was 191 and indicated no insulin was administered. Review of the MAR for August 2012 indicated a lack of documentation for BG testing and any insulin administration for 8-21-12, 8-22-12 and 8-23-12 for supper and bedtime. The facility was unable to		Quality Assurance Committee will require Corrective Action Plan for any pattern of non-compliance	

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	provide a copy of the MAR for September 2012 prior to the end of the survey to indicate the BG and insulin information. In interview with LPN #1 on 9-18-12 at 2:37 p.m., she indicated, "I have no excuse whatsoever for not charting [name of Resident #A]'s blood sugars and insulin. I can tell you he expected his blood sugar each evening at 4pm and 9pm sharp. I don't recall not doing them, but I have no excuse for not charting them." 2. Resident #C's clinical record was reviewed on 9-18-12 at 9:31 a.m. Her diagnoses included, but were not limited to diabetes and chronic leg wounds. Physician orders indicated she was to have BG testing performed before each meal and at bedtime, with a sliding scale dose of insulin to be given before each meal and at bedtime, based on the BG results. The sliding scale insulin orders indicated to give no insulin if the BG was under 141. From 141 to 200, to administer 1 unit of insulin; from 201 to 250, administer 2 units of insulin; from 251 to 300, administer 3 units of insulin; from 301 to 350, administer 4 units of insulin; from 351 to 400, administer 5 units of insulin; for over 400, administer 10 units of insulin and the facility was to contact the physician for further			

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	instructions for care. Review of the August 2012 MAR indicated on 8-3-12, the supper BG was 148 and no insulin was administered; on 8-11-12, the lunch BG was 150 and no insulin was administered; on 8-12-12, the lunch BG was 215 and no insulin was given. Review of the September 2012 MAR indicated on the supper BG on 9-14-12 and 9-15-12 was 143 and no insulin was administered. Review of the MAR for August 2012 indicated a lack of documentation for BG testing and insulin administration for bedtime on 8-3-12; for breakfast, lunch, supper and bedtime on 8-8-12; for supper and bedtime on 8-9-12; for supper and bedtime on 8-13-12, 8-14-12 and 8-15-12; for breakfast, lunch, supper and bedtime on 8-16-12; for breakfast and lunch on 8-17-12; for breakfast on 8-20-12; for supper and bedtime on 8-21-12, 8-22-12 and 8-23-12; for supper and bedtime on 8-28-12; for breakfast, supper and bedtime on 8-29-12 and for lunch on 8-30-12. Review of the MAR for September 2012 indicated a lack of documentation for BG testing and insulin administration for			

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	supper 9-3-12; for supper and bedtime for 9-10-12, 9-11-12 and 9-12-12; for breakfast and lunch 9-14-12 and for supper and bedtime on 9-16-12. 3. The clinical record of Resident #D was reviewed on 9-18-12 at 10:15 a.m. His diagnoses included, but were not limited to diabetes, dementia, neuropathy and gouty arthritis. Physician orders indicated he was to have BG testing performed before each meal and at bedtime, with a sliding scale dose of insulin to be given before each meal and at bedtime, based on the BG results. The sliding scale insulin orders indicated to give no insulin if the BG was under 141. From 141 to 200, to administer 2 units of insulin; from 201 to 250, administer 4 units of insulin; from 251 to 300, administer 6 units of insulin; from 301 to 350, administer 8 units of insulin; from 351 to 400, administer 10 units of insulin; for over 400, administer 16 units of insulin and the facility was to contact the physician for further instructions for care. Review of the August 2012 MAR indicated on 8-7-12, the bedtime BG was 198 and no insulin was administered; on 8-9-12, the breakfast BG was 145 and no insulin was administered; on 8-10-12, the			

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	lunch BG was 149 and 1 unit of insulin was administered; on 8-19-12, the bedtime BG was 249 and 6 units of insulin was administered; on 8-22-12, the lunch BG was 201 and 2 units of insulin was administered. Review of the September 2012 MAR did not indicate any incorrect dosages of insulin administered based on BG results. Review of the MAR for August 2012 indicated a lack of documentation for BG testing and insulin administration for breakfast and lunch on 8-2-12, 8-4-12 and 8-6-12; for lunch on 8-7-12; for breakfast, lunch, supper and bedtime on 8-8-12; for bedtime on 8-9-12; for supper and bedtime on 8-13-12, 8-14-12, 8-15-12 and 8-16-12; for breakfast and lunch on 8-17-12; for supper and bedtime on 8-21-12, 8-22-12, 8-23-12, 8-27-12 and 8-28-12. Review of the MAR for September 2012 indicated a lack of documentation for BG testing and insulin administration for supper on 9-3-12; for supper and bedtime on 9-10-12, 9-11-12, 9-12-12 and 9-16-12. A policy entitled, "Specific Medication Administration Procedures," with an effective date of 2-1-2010 was provided by the Director of Nursing on 9-18-12 at			

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	12:57 p.m. This document indicated the "Policy: To administer medications in a safe and effective manner...Check MAR for [physician's medication] order...Read medication label three (3) times: 1) prior to removing the medication package/container from the cart/drawer; 2) prior to removing the medication from the package/container; 3) as the package/container is returned to the cart/drawer. Compare label to MAR...Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. After administration, return to cart, replace medication container (if multi-dose and doses remain) and document administration in the MAR or TAR [Treatment Administration Record]...If resident refuses medication, document refusal in MAR or TAR..." This federal tag relates to complaint IN00115487. 3.1-50(a) 3.1-50 (a)(1) 3.1-50 (a)(2) 3.1-50 (f)(3)			